288518

PUBLIC SERVICE COMMISSION OF SOUTH CAROLINA
101 Executive Center Drive, Suite 100
Columbia, South Carolina 29210

2019-355T

Phone: (803) 896-5100 Fax: (803) 896-5199

APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY FOR OPERATION OF MOTOR VEHICLE CARRIER

CLASS C - NON-EMERGENCY Date: NOV. 10, 2019

Application is hereby made for a Certificate of Public Convenience and Necessity, in accordance with the provision of S.C. Code Ann., § 58-23-10, et seq. (1976), and amendments thereto.

1. Carolina Med Trans LLC
Name under which business is to be conducted (corporation, partnership, or sole proprietorship, with or without trade name.)

738 Coventry Lane #D Florence, SC 29501
Street Address of Applicant

Mailing Address of Applicant (if different from street address)

843-921-9996 Phone | 843-921-9997 Fax

~~9[illegible]~~ hcraignorton@icloud.com
Email Address

2. If the Applicant is an LLC or a corporation, a copy of the Certificate of Existence from the South Carolina Secretary of State and the Articles of Incorporation must be attached. (If incorporated outside of SC, attach South Carolina Secretary of State "Foreign Corporation" Certificate.)

3. Select Entity Type: (Check one)
   - ☐ Individual Owner/Sole Proprietorship
   - ☐ Partnership - List names and address of all person having an interest in the business.
   - ☒ Corporation - List names and addresses of two principal officers.

Hubert Norton 738 Coventry Lane #D Florence SC V-P
Elizabeth D. Norton 810 N. Wilson Dr Chesaw, SC President

Applicant is financially able to furnish the services as specified in this application and submits the following statement of assets and liabilities.

Financial Statement

Applicant's assets and liabilities are as follows:

Assets:		Liabilities:	
Value of Real Estate	Rent	Mortgage/Loan on Real Estate	-0-
Value of Motor Vehicles	63,000.00	Loans Owed on Motor Vehicles	-0-
Cash on Hand	19,000.00	Business/Other Loans Owed	-0-
Cash in Bank	7500.00	Other Liabilities or Debts	Ins. 16,000.00
Value of Other Assets and Equipment	30,000.00	**Total Liabilities**	16,000.00 ✓
Total Assets	119,500 ✓		

INSTRUCTIONS:

1. "Value of Real Estate" means the actual or estimated market value of any real property/buildings owned by the Company/Business Applying for a Certificate.
2. "Mortgage/Loan on Real Estate" means the outstanding balance on any Mortgage, Equity Line or other Loan secured by the Real Estate listed in Item 1.
3. "Value of Motor Vehicles" means the actual or fair estimated value of any moving vans, trucks or other vehicles owned by the Company/Business Applying for a Certificate.
4. "Loans Owed on Motor Vehicles" means the outstanding balance on any loans or liens on the vehicles listed in Item 3.
5. "Cash on Hand" is the total of actual cash held by the Company/Business applying for a Certificate on the day this form is filled out.
6. "Business/Other Loans Owed" means the outstanding balance on any small business loan or other unsecured loan made by a person, bank or business to the Business/Company applying for a Certificate.
7. "Cash in Bank" means the current balance in checking accounts, savings accounts or the like in the name of the Company/Business applying for a Certificate. Do not include retirement accounts or personal bank account balances.
8. "Value of Other Assets and Equipment" should include the actual or estimated value of items such as office equipment (computers/furnishings), moving equipment (hand trucks/blankets/strapping), and trailers.
9. "Other Liabilities or Debts" means specific amounts/balances which the Company/Business applying for a Certificate knows that it owes to other persons or companies; for example Franchise Fees. This does NOT include regular bills such as electricity bills, security system costs, insurance, salaries, etc.

PROPOSED RATES AND CHARGES FOR SERVICE

Proposed Rates and Charges:

40.00 Base Rate
2.00 per loaded mile

Requested Scope of Authority: Check all counties in which you are requesting permission to operate. You will only be allowed to operate in those counties checked below. You may request "Statewide" authority if you intend to operate in all counties in South Carolina.

☐ Abbeville	☐ Cherokee	☒ Florence	☒ Lee	☐ Saluda
☐ Aiken	☐ Chester	☐ Georgetown	☐ Lexington	☐ Spartanburg
☐ Allendale	☒ Chesterfield	☐ Greenville	☐ Marion	☐ Sumter
☐ Anderson	☐ Clarendon	☐ Greenwood	☒ Marlboro	☐ Union
☐ Bamberg	☐ Colleton	☐ Hampton	☐ McCormick	☐ Williamsburg
☐ Barnwell	☒ Darlington	☐ Horry	☐ Newberry	☐ York
☐ Beaufort	☒ Dillon	☐ Jasper	☐ Oconee	
☐ Berkeley	☐ Dorchester	☐ Kershaw	☐ Orangeburg	☐ Statewide
☐ Calhoun	☐ Edgefield	☒ Lancaster	☐ Pickens	
☐ Charleston	☐ Fairfield	☐ Laurens	☐ Richland	

DESCRIPTION OF EQUIPMENT

You are **not** required to own a vehicle to file an application. However, prior to being issued a certificate by ORS, you will be required to have obtained a vehicle.

Maximum Number of Passengers Vehicle is Equipped to Carry: (The number of passengers a vehicle is equipped to carry is based on the number of **seatbelts** in the vehicle, including the driver's seatbelt.)

☒ 1-7 Passengers, including driver

☐ 8-15 Passengers, including driver

MAKE	YEAR & MODEL	VIN#	EMPTY WEIGHT	WHEEL-CHAIR LIFT
Ford	2014 Econoline Van	1FTNS2EW1EDA65254	5376	yes
Ford	2008 Econoline Van	1FTNE14W08DB59889	4991	yes
Ford	2013 Econoline Van	1FTNS2EW4DDA65246	5376	yes
Ford	2013 Econoline Van	1FTNS2EWXDDA78454	5376	yes
Ford	2011 Econoline Van	1FTNE2EW9BDA16564	5080	yes

INSURANCE QUOTE

This form **MUST BE COMPLETED.**
The insurance quote must be complete, listing current insurance premiums. At the discretion of the Commission, a copy of current insurance policies may be required. Do not provide a copy of insurance policies unless requested. You will not be required to purchase insurance until your application has been approved and an order has been issued by the PSC. THIS IS ONLY A QUOTE.

The following insurance quote is for:

Carolina Med Trans LLC
Name of Applicant

738 Coventry Lane unit D Florence SC
Address of Applicant

Amount of Premium:

Liability Insurance $ 79,279.00

The above quoted premium is for a term of 12 months.

Minimum Limits - Bodily injury and property damage limits will not be less than the following:

		Limits Quoted
Liability Combined Each Occurance	$ 1,000,000	1,000,000
Medical Payments per Person	$ 1,000	2,500 00

Prime Property + Casualty Insurance Co
Name of Insurance Company

8722 South Harrison St Sandy UT 84070
Home Office Address of Company

I, the Applicant, am familiar with the Commission's Rules and Regulations relating to insurance requirements and the above quote meets the minimum insurance limits prescribed. The insurance company making this quote is authorized by the South Carolina Department of Insurance to do business in South Carolina.

NOTICE:
If you wish to self-insure your motor vehicles for liability and property damage, you must comply with S.C. Code Ann. Sections 56-9-60 and 58-23-910. For more information, contact the Department of Motor Vehicles at (803) 896-8457 or (803) 896-9903.

If you wish to apply as a self-insured for worker's compensation coverage in South Carolina you may do so with the South Carolina Worker's Compensation Commission (WCC) provided that you will be able to: 1) post a surety bond or letter-of-credit with the WCC for a minimum of $500,000, 2) agree to pay a yearly self-insurance tax, and 3) agree to pay an annual assessment to the South Carolina Second Injury Fund. For more information, contact the WCC Self-Insurance Division at (803) 737-5712 or on the web at www.wcc.state.sc.us/self-insurance.

Exhibit Fit, Willing, and Able (FWA)

Carolina Med-Trans LLC
Name

1. Is there currently any outstanding judgments against the Applicant?
   ○ Yes ☒ No
   If Yes, list judgements here:

2. Is Applicant familiar with all statutes and regulations, including safety regulations and governing for-hire motor carrier operations in South South Carolina, and does Applicant agree to operate in compliance with these statutes and regulations?
   ☒ Yes ○ No

3. Is Applicant aware of the Commission's insurance requirements and the insurance premium costs associated therewith?
   ☒ Yes ○ No

Exhibit on Driver Qualifications

1. Applicant understands that drivers must possess at least a current American Red Cross Standard First Aid and CPR Certificate or its equivalent, and records that verify/record such training must be kept on file at the company's primary place of of business within South Carolina.

   ⊗ Yes ○ No

2. Applicant understands that drivers must be in compliance with all OSHA regulations.

   ⊗ Yes ○ No

3. Applicant understands that drivers must be trained in the use of all vehicle installed safety equipment such as two-way radios, first-aid kits, fire extinguishers, and other equipment as outlined in PSC Regulations.

   ⊗ Yes ○ No

4. Applicant understands that drivers must be able to physically perform actions necessary to assist persons with disabilities, including wheelchair users.

   ⊗ Yes ○ No

5. Applicant understands that drivers must wear a professional uniform and photo identification badge that easily identifies the driver and the company for whom the driver works.

   ⊗ Yes ○ No

6. Applicant understands that drivers must complete twelve (12) hours of in-service training annually in the area of safety, and records that verify/record such training must be kept on file at the company's primary place of business within South Carolina.

   ⊗ Yes ○ No

PUBLIC SERVICE COMMISSION OF SOUTH CAROLINA
101 EXECUTIVE CENTER DRIVE, SUITE 100
COLUMBIA, SOUTH CAROLINA 29210

Applicant is familiar with the provision of S.C. Code Ann. §58-23-10, et seq.(1976), and amendments thereto, and R.103-100 through R.103-241 of the Commission's Rules and Regulations for Motor Carriers (S.C. Code Ann. Regs., 1976), and R.38-400 through R.38-503 of the Department of Public Safety's Rules and Regulations for Motor Carriers (Volume 2, S.C. Code Ann., 1976) and amendments thereto, and hereby promises compliance therewith.

S.C. Code Ann. Section 58-3-250 states, in part, that every final order of the Commission must be served by electronic service, registered or certified mail, upon the parties to the proceeding or their attorneys.

Please check the applicable box:

☒ The Applicant AGREES to receive future Commission orders related to the Applicant's authority in South Carolina through the Commission's eService System. The Applicant authorizes the Commission to serve its orders by using the e-mail address as it appears on page one of this Application. To sign up for eService notifications, please visit www.psc.sc.gov to create a My DMS account.

☐ The Applicant DOES NOT AGREE to receive future Commission orders related to the Applicant's authority in South Carolina through the Commission's eService System.

The Applicant for the Certificate of Public Convenience and Necessity as set forth in the foregoing, swear or affirm that all statements contained in the above application are true and correct.

Hubert Norton
Applicant's Signature

Vice President
Title of Applicant (e.g. President, Owner, etc.)

STATE OF SOUTH CAROLINA)
COUNTY OF Florence)

SWORN TO BEFORE ME
This 12th day of November, 20 19

Brenda J. Macchio
Notary Public

Commission Expires 10/24/2026

BRENDA J. MACCHIO NOTARY PUBLIC COMM. EXP. 10-24-2026 SOUTH CAROLINA

Print Application

8722 S. Harrison St., Sandy, UT 84070
P.O. Box 4439, Sandy, UT 84091
Phone: 800-257-5590 - Fax: 877-452-6910
Website:
E-mail:

11/1/2019

Binddesk Insurance Services
PO Box 1908 La Mesa
San Diego, CA 919444

Re: Carolina Med Trans LLC

Below please find an Indication Quote. In order to accommodate the Insurer's underwriting parameters and/or the Insured's premium preference, the Quote may contain coverage options or be based upon factors such as lower Limits of Liability or a higher Self-Insured Retention or Deductible than what was stated as preferred on the Application. Accordingly, please read the Quote carefully.

INDICATION QUOTE

This is an Indication Quote only. The prices listed below are subject to review and change after receipt of any requested additional information. Be aware that the Insurer is not obligated to bind any risk based on the following information. This Indication Quote expires after 30 days

Quote Number: BN1910985-1 Customer Number: D19-210985

Underwriter: Benjamin Nichols Direct Phone No.: (801) 304-3787 E-Mail: benjaminn@primeis.com

Note: Please review the following coverage(s) as presented. Coverage may differ from the coverage requested on the application/ submission. Any changes must be submitted to the underwriter in writing for approval and pricing.

Description of Risk(s): Paratransit Service
Description of Coverage: Commercial Auto Liability and Physical Damage

Minimum Earned: 25%

Premium:	**$79,029.00**
Policy/Inspection Fee:	**$250.00**
Total:	**$79,279.00**

To Bind Coverage: Payment must be received before coverage can be bound.

Conditions: Review and comply with all the conditions below and complete and return all requirements on the coverage request form.

Coverage is based on: 6 wheelchair lift equipped vans and 8 drivers.

Defense coverage is within the limits of liability.

If Higher Liability Limits are required by the insured, please contact underwriting for a formal quote.

Quote assumes no filings. If filings are needed, Signed Loss Adjustment and Collateral Agreement required along with approved security prior to binding.

If using outside finance companies, the underwriter must be notified prior to binding - sample policy forms will be sent.

Only scheduled vehicles are covered on the policy.

Personal Guarantee form must be signed by the principal owner and/or officer of the business and must be notarized.

Subject to the insured's completion of a discussion call with our Risk Management Department within 30 days of binding coverage. Toll Free 877-585-2851

Signed UM/UIM/PIP selection / rejection form required.

Towing & Labor Costs are excluded - terms can be offered for additional premium, physical damage coverage must be purchased.

Agent/broker may not charge any kind of fee to the Insured that is different from or exceeds the premiums and fees set forth in the quote, unless specifically authorized by us in writing.

All Drivers are subject to Driver Premium Charges: processing charge, 5 years MVR, and CDL experience. MVR charges are fully earned.

Subject to a 75 mile radius

Only carrier can issue vehicle identification cards.

The Policy Receipt Form (PRF) must be signed and returned to us within 10 days of the receipt of the Policy. In the event the PRF is not timely returned, we reserve the right to issue a Notice of Cancelation (NOC).

PPCI Auto Physical Damage - Stated Amount Insurance endorsement applies

Provide a government issued document evidencing the exact name of the legal entity to be insured, including any DBA's or alternative names

Quote excludes Additional Insureds (AIs) unless specifically outlined in the quote documents. AIs can be added for additional premium

Registration/plates must be surrendered for all company owned vehicles not scheduled under this policy.

Subject to MVR surcharges for MVRs not processed.
Pictures of all scheduled vehicles required prior to binding.
PPCI Auto Physical Damage - Stated Amount Insurance endorsement applies

8722 S. Harrison St., Sandy, UT 84070
P.O. Box 4439, Sandy, UT 84091
Phone: 800-257-5590 - Fax: 877-452-6910
Website:
E-mail:

Commercial Auto:

$1,000,000	Combined Single Limit (CSL)	$25,000	UM Per Person
$2,500	Liability Deductible	$50,000	UM Per Accident
$2,500	Physical Damage Deductible	$25,000	UM Property Damage
$5,000	Covered Pollution Cost or Expense / Property Damage Cleanup Sublimit	$25,000	UIM Per Person
		$50,000	UIM Per Accident
		$25,000	UIM Property Damage

Number of Vehicles: 6 Number of Drivers: 8
Item 2: 7

$56,000 Physical Damage-total scheduled value

Other Coverages Available: (Additional underwriting required and an increase in premium, if accepted)
Limited Terrorism Coverage

Request for Motor Carrier Insurance Filings/Financial Responsibility Filings

Are you subject to any governmental filing requirements? ☐ Yes ☐ No
If yes, please indicate what filing/forms you are required to file below.

Prime Insurance Company shall not be liable for the non-filing of any required filing/form or for any filing deficiencies directly or indirectly caused by your failure to completely and accurately disclose any requirement to which you are subject.

Caution: If your regulatory authority has you listed under a name that varies from the name on your policy, then your filings may be rejected.

Call: 800-257-5590 EXT 5010 for Customer Assistance.

FEDERAL FILINGS - FMCSA - Federal Motor Carrier Safety Administration

☐ USDOT number: _____ ☐ 91 X Filing ☐ Cargo Filing BMC3
☐ Docket number: _____ ☐ MCS-90 Certificate

STATE FILINGS - Name of State: _____

☐ Form E ☐ California – MC 65 – Certificate – Motor Carrier # _____ (mandat
☐ Form F ☐ California – MC 67 – Endorsement – Motor Carrier #_____ (mandat
☐ Form H ☐ Maine JB Filing
☐ Form I ☐ Pennsylvania PPA
☐ Form T - Texas VSF # _____ ☐ Pennsylvania PUC - A#
☐ WMATC Certificate - Washington. Maryland, Virginia ☐ Other State Certificate (Form name If known) _____
☐ Certificate - our form - Proof of Insurance Certificates to your state authority will not be issued unless the following information is completed:

Name issued to: _____

Address: _____ City, State & Zip: _____

Fax number: _____ E-mail: _____

☐ OTHER - If the filing you need is not shown on this form, then please indicate what you need and to whom it should be issued:

Please Sign and Return this Form

PERSONAL GUARANTEE AND INDEMNITY AGREEMENT

I, the undersigned, in my individual capacity, hereby enter into this Personal Guarantee and Indemnity Agreement ("Agreement") which is effective as of the date indicated below and which shall continue in force until such time as it is mutually cancelled with the written approval of the Insurer.

I hereby agree to personally indemnify and hold the Insurer harmless from any and all costs, attorneys fees, expenses, settlement proceeds, or other funds expended or deemed owing as a result of the following:

(1) Any failure by the Insured to pay all premiums, self-insured retentions and/or deductibles owed, including but not limited to the minimum earned premium due.

(2) Any claim involving a vehicle which was not properly scheduled on the Policy for which claim the Insurer is nevertheless required to make any payment as a result of any federal or state financial responsibility filing, including without limitation, any MCS-90, Form E or similar undertaking.

(3) Any claim involving a driver who was not properly scheduled on the Policy for which claim the Insurer is nevertheless required to make any payment as a result of any federal or state financial responsibility filing, including without limitation, any MCS-90, Form E or similar undertaking.

In addition, I hereby personally agree to pay all premiums, self-insured retentions and/or deductibles owed by the Insured, including but not limited to the minimum earned premium due, should the Insured fail to pay such premiums, self-insured retentions and/or deductibles by the date due and owing. I also hereby personally agree to pay all premiums, self-insured retentions and/or deductibles which should have been paid for an unscheduled driver and/or an unscheduled vehicle in the event one of the above-referenced types of claims is made.

The Insurer reserves the right to assess the full annual premium for any unscheduled vehicles and/or drivers. Such assessment is due and payable on the date of discovery. Unscheduled vehicles and/or drivers will be added to the Policy effective as of Policy inception or the discovery date, at the Insurer's discretion. Either way, premium will be due or my Policy will be cancelled. A 35-day notice of cancellation will be issued on the Policy and I am limited to the 35-day notice period to rectify a finding of unscheduled vehicles and/or drivers.

I acknowledge and agree that my obligations as set forth herein are not diminished or otherwise altered by a change in ownership or management of the insured entity, or by bankruptcy, dissolution, insolvency or any other change with respect to the insured entity.

All amounts payable by me under this Agreement shall be paid within 35-days of written notice provided to me by the Insurer. In the event such amounts are not paid within that time, I acknowledge and agree that I will be responsible for all collection costs, including reasonable attorneys fees.

Furthermore, I hereby elect to apply any and all unearned premium to unpaid balances of this Policy or any other policy I may hold or have held with the Insurer in the event this Policy is cancelled, whether by me or by the Insurer.

INSURED'S NAME: _____

NAME OF OWNER/NAMED INDIVIDUAL: _____,

OWNER'S/NAMED INDIVIDUAL'S SIGNATURE: _____, DATED: _____

Subscribed and Signed before me A NOTARY OF _____
(State or Location)

this: _____ day of _____, 20 _____.

_____
Notary Public

Insurance only works when risks are shared among similarly situated people and businesses. I know that the claims I submit will affect the risks that I am sharing with others. I also understand that my relationship with Prime Property and Casualty Insurance, Inc. depends on honesty. I trust that Prime Property and Casualty Insurance, Inc will be honest with me and I promise to be honest with them. I know that it would be dishonest to submit an inflated insurance claim. I also know that it would be dishonest to exaggerate about the events surrounding the accident that resulted in an insurance claim. My integrity is important to me and I promise to maintain a high moral standard in my dealings with Prime Property and Casualty Insurance, Inc.

OWNER'S/NAMED INDIVIDUAL'S SIGNATURE: _____, DATED: _____

Greenlight Premium Financing Options

(Monthly Payments as low as: $5,682.41)

Please Sign and Return this Form

Quote date: 11/1/2019

Company name: Caroline [redacted] LLC

Customer number: [redacted]

Total premium due (includes taxes and fees): $79,279.00

If you want to finance, INITIAL the option containing the finance terms of your choice.

Choose ONLY ONE option otherwise 100% of the total premium is due.

	25% Down Payment * $19,819.75 *Auto draft monthly payments are required	30% Down Payment $23,783.70	40% Down Payment $31,711.60
3 Monthly Payments	_____ Initial Here	_____ Initial Here	_____ Initial Here
	3 @ $20,322.63	3 @ $18,968.68	3 @ $16,260.77
Interest Rate	14.75%	14.75%	14.75%
Finance Charge	$1,508.64	$1,410.73	$1,214.91
Final APR**	15.16 %	15.19 %	15.26 %
Amount Financed	$59,459.25	$55,495.30	$47,567.40
Total of Payments	$60,967.89	$56,906.03	$48,782.31
5 Monthly Payments	_____ Initial Here	_____ Initial Here	_____ Initial Here
	5 @ $12,394.55	5 @ $11,568.78	5 @ $9,917.24
Interest Rate	16.50%	16.50%	16.50%
Finance Charge	$2,513.50	$2,348.60	$2,018.80
Final APR**	16.76 %	16.78 %	16.82 %
Amount Financed	$59,459.25	$55,495.30	$47,567.40
Total of Payments	$61,972.75	$57,843.90	$49,586.20
7 Monthly Payments	_____ Initial Here	_____ Initial Here	_____ Initial Here
	7 @ $8,995.10	7 @ $8,395.81	7 @ $7,197.23
Interest Rate	17.25%	17.25%	17.25%
Finance Charge	$3,506.47	$3,275.38	$2,813.18
Final APR**	17.44 %	17.46 %	17.49 %
Amount Financed	$59,459.25	$55,495.30	$47,567.40
Total of Payments	$62,965.72	$58,770.68	$50,380.58
9 Monthly Payments	_____ Initial Here	_____ Initial Here	_____ Initial Here
	9 @ $7,101.90	9 @ $6,628.73	9 @ $5,682.41
Interest Rate	17.50%	17.50%	17.50%
Finance Charge	$4,457.82	$4,163.30	$3,574.26
Final APR**	17.65 %	17.66 %	17.69 %
Amount Financed	$59,459.25	$55,495.30	$47,567.40
Total of Payments	$63,917.07	$59,658.60	$51,141.66

☐ **Check this box if you would like to setup your monthly payments to be auto drafted (this option is for 30 & 40% down, all 25% down payments will automatically be setup up for auto drafts).**

After initialing an option listed above, sign the agreement on the next page and attach a check for the down payment amount shown in your selected option above.

***Note: All 25% down payment options require an automatic draft from your bank account monthly.**

**Note: Final APR is based on the annual percentage rate plus fees for the duration of the number of monthly payments selected.
This is not a loan document and is not binding on any premium finance company to accept any loan for the undersigned.
The first payment is due in 30 days after the coverage effective date.

Greenlight Premium Financing Request (Continued)

Please Sign and Return this Form

☐ **Yes, I want to finance** according to the option selected on the previous page (please sign and see down payment methods below)
(Note: All 25% down payment options require an automatic draft from your bank account monthly.)

The undersigned insured/member requests that, Prime Property & Casualty Insurance Inc. (PPCI) a Utah company, arrange the financing for its premium in monthly installments and hereby irrevocably appoints PPCI a limited power of attorney to complete and execute a premium financing agreement on its behalf.

The undersigned shall have the right to, without charge, rescind by paying to PPCI the net amount financed on the financing agreement executed on its behalf by (PPCI) within 10 days after PPCI or the actual premium finance company (PFC) mails to the undersigned a true copy of the actual premium financing agreement being executed by PPCI as attorney-in fact for the undersigned. Failure to rescind shall be deemed a ratification and affirmation of the actions of the attorney-in-fact in the execution of a premium financing.

Security Interest: Borrower hereby gives the PFC a security interest in and assigns any amount payable to Borrower under the policy to first satisfy any amounts owed by borrower to PFC, including interest, late fees or cancellation charges. Borrower agrees that PFC shall be listed as a loss payee on the policy and that PFC's interest shall have priority over any other loss payees or lienholders. This security interest shall include, without limitation, any and all unearned premiums and dividends which may be payable under the insurance policies listed in the Schedule of Policies, loss payments which reduce the unearned premiums, and any interest arising under a state guarantee fund relating to these items.

☐ **No, I do not want to finance.** I am paying 100% of the total premium listed on my quote. (See payment methods below)

Authorization to Set Up Financing

I, the Insured, have read and authorize PPCI to set up financing according to my selection on the previous page.

Signature _____ Date _____

Print name and title _____

PAYMENT METHOD: PAY BY WIRE, PHONE, FAX, OR MAIL

BANK WIRE	CHECK VIA OVERNIGHT OR EXPRESS MAIL	CHECK BY FAX CREDIT CARD BY PHONE
Account name: Prime Property & Casualty Insurance Inc.	PPCI	**FAX:** 1-877 452 6910
Bank name: People's Intermountain Bank	8722 South Harrison St, Sandy, UT 84070	**E-MAIL:** ar@primeis.com
Telephone:		
Routing no:		**PHONE:** 1-877-257-5590
Account n		

CHECK DISCLOSURE:

Checks received may be processed electronically. The Company, through its bank, has the ability to provide electronic check processing rather than submitting a paper copy of the check to the bank. Funds transfer in the same manner if transacted electronically or by submitting a paper copy of the check to the bank, except funds transfer the day the information is received with electronic processing rather than within a few business days as with a paper check. Electronically processed checks transactions appear on your bank statement in the same manner as paper checks. Charge will appear as 'Prime Property & Casualty Insurance Inc.'

CHECK BY FAX METHOD:

1. Make out physical check, payable to Prime Property & Casualty Insurance Inc. Date and sign the check, but do not mail it.
2. Complete and sign the authorization, giving us permission to convert check to an EFT (Electronic Funds Transfer). Transaction will appear as a debit from PRIME PROP & CAS.
3. Tape the check to this form, where indicated at the bottom. Fax this form and check to 1-877 452 6910
4. Keep this form and original check. DO NOT MAIL IT

Attach Check here or Enter Check Information:

Bank name and address: _____

Bank routing no.(usually 9 digits): _____ **Account no.:** _____

Amount of check: $ _____ **Check no.:** _____

Authorized by: _____ **Date:** _____

Signature of authorization: _____ **Date:** _____

IF FINANCING: Attach an additional check if you would like to use a different account for your auto draft monthly payments.

SERVICE FEE: PPCI reserves the right to collect directly from your account a processing fee of $25 for any incomplete transaction due to insufficient funds in your account (i.e. a "bounced check").

This is not a loan document and is not binding on any premium finance company to accept any loan for the undersigned.
The first payment is due in 30 days after the coverage effective date.

Please Sign and Return this Form

COVERAGE REQUEST FORM

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Applicant: Carolina Med Trans LLC Sub-Produce[illegible]Binddesk Insurance Services

Quote #: [illegible] ount due: $79,279.00 Requested bind date: [illegible]

Coverage [illegible] uments are received:

- ☐ ■ A valid Indication Quote with all requirements reviewed and complied with.
- ☐ ■ A completed and signed Coverage Request Form.
- ☐ ■ A completed and signed Application.
- ☐ ■ Amount due to bind Policy, in full, unless financed through Greenlight Premium Finance, in which case attach the payment terms. Finance agreement must be completed and signed by the Insured.
- ☐ ■ All check by fax or electronic checks presented to bind or add coverage will be processed via electronic funds transfer ("EFT") and must be on an account which authorizes this type of transaction.
- ☐ ■ A completed and signed Application, Claims History and Incident Disclosure History form.

Special conditions to bind:

Personal Guarantee form must be signed by the principal owner and/or officer of the business and must be notarized.

Pictures of all scheduled vehicles required prior to binding.

Provide a government issued document evidencing the exact name of the legal entity to be insured, including any DBA's or alternative names

Signed UM/UIM/PIP selection / rejection form required.

The Applicant also acknowledges and agrees that the policy may be issued with special instructions or at an increased premium from those rates and forms filed with the Department of Insurance.

I understand and agree the amount charged is in consideration for the insurance coverage that I have reviewed and approved. I understand the amount is non-refundable and is not subject to dispute. I acknowledge I am advised of the associated minimum earned premium, which is the least amount due and owing on the date of inception and is non-refundable.

(YOU MUST MAKE A SELECTION BELOW)

Do you require any additional insured certificates, waiver of subrogation, hold harmless agreements, or proof of insurance?

☐ Yes ☐ No If yes, please provide a detailed list for each entity, including name, address, contact name and e-mail. If you have more than five (5) please submit an excel spreadsheet or the Policy Services Department can provide you with one. Please note that additional premium may apply

☐ By checking this box, I hereby consent to the insurer and its insurance affiliates processing the personal data disclosed as part of the application process for purposes of evaluation and issuing insurance products to me by the insurer and its affiliates. I understand that the insurer may share the information disclosed as part of the application process for evaluating and issuing insurance products and risk management services, but that the insurer will not disclose my personal information to unaffiliated advertisers or vendors. I acknowledge that I have the right to withdraw my consent to the insurer's use of my personal data by notifying it in writing or the withdrawal of my consent.

By signing below, the applicant consents to electronic communication.

Applicant's signature/Date

Signature of broker/agent of applicant/date

Print applicant's name

Print broker/agent name

CLAIMS WARRANTY AND COVERAGE STATEMENT

Please Sign and Return this Form

ACA-99-12

Coverage provided under the Policy is contingent on the following warranty, requirements, and acknowledgements as evidenced by the Applicant's signature.

WARRANTY STATEMENT

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this statement, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) all supplemental information and documents provided in conjunction with the Application are warranties that may become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance. The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit reporting agencies.

FUTURE CLAIM INCIDENT/REPORTING REQUIREMENT

As an express condition precedent to coverage under this Policy, you must give us immediate written notice no later than 72 hours after any incident, event, occurrence, loss, or Accident which might give rise to a Claim covered by this Policy. Written notice must be given to: Claims Direct Access, P.O. Box 4439, Sandy, Utah 84091-4439, U.S.A. Phone: (877) 585-2849 or (801) 304-5530; Fax: (877) 452-6909 or (801) 304-5536.

ACKNOWLEDGEMENT OF RESTRICTIVE COVERAGES

Coverage is provided only for otherwise covered Claims which result form an Accident occurring during the Policy Period. In addition, coverage is strictly limited to those activities and operations and at those locations listed, described, and defined in the Policy. Please read the Policy and all Endorsements carefully to determine your rights and duties and what is and is not covered.
The Applicant expressly understands, acknowledges, and agrees that (i) a one-time $250 policy fee will be assessed at policy inception. This policy fee is fully; accordingly, no refund will be made regardless of whether the Policy is cancelled by the covered party or the Insurer for any reason, (ii) a $50 additional charge will be added for any Additional Insured; (iii) a $10 service fee will be charged for every driver change; (iv) a flat charge will be assessed for Driver Surcharge(s) and MVR Surcharge(s); (v) a $25 charge may be charged to reinstate any policy cancelled for nonpayment of premium; (vi) a $5 fee will be added to each monthly payment if the Applicant elects a payment plan.

NOTICE OF TERRORISM INSURANCE COVERAGES

You are hereby notified that under the Terrorism Risk Insurance Act as extended on December 22, 2005, (the "Act"), that you now have a right to purchase insurance coverage for losses resulting from acts of terrorism, as defined in Section 102(1) of the Act. The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States- to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property; or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

Exclusions for acts of terrorism apply only if the act(s) of terrorism result(s) in industry-wide insured losses that exceed $25,000,000 for related incidents that occur within a 72-hour period; or fifty or more persons sustain death or serious physical injury for related incidents that occur within a 72-hour period. For purposes of this provision, "serious physical injury" means: (i) physical injury that involves a substantial risk of death; (ii) protracted and obvious physical disfigurement; or (iii) protracted loss of or impairment of the function of a bodily member or organ. Exclusions for acts of terrorism are not subject to the limitations above if: (i) the act involves the use, release or escape of nuclear materials, or that directly or indirectly results in nuclear reaction or radiation or radioactive contamination; (ii) the act is carried out by means of the dispersal or application of pathogenic or poisonous biological or chemical materials; or (iii) pathogenic or poisonous biological or chemical materials are released, and it appears that one purpose of the terrorism was to release such materials.
Coverage under your Policy may be affected as follows:

(YOU MUST MAKE A SELECTION)

☐	I hereby elect to purchase coverage, subject to the limitations of the Act, for acts of terrorism, as defined in the Act, for 20% increase in premium, if accepted.
☐	I hereby decline coverage for terrorism. I understand that I will have no coverage for losses resulting from acts of terrorism.

All other terms and conditions of this Policy remain unchanged.

Applicant's Signature/Date

Signature of Broker/Agent of Applicant/Date

Print Applicant's Name

Print Broker/Agent Name

ACA-99-12 15MAY2014

Please Sign and Return this Form

INSURED CONTACT FORM

Prime's Risk Management Department fosters a mutually beneficial relationship with every insured by taking a partnership approach to the management of each insured's account.

We begin this partnership with a call to the insured where we:

- Welcome the insured to the company,
- Review policy terms, limits, and conditions,
- Establish a direct point of contact for risk management related concerns.

In addition to the conditions of the policy, below are three requirements that the applicant needs to complete during the policy period:

1. Return a signed copy of the Policy Receipt Form and Coverage Conditions Summary to the Risk Management Department within 10 calendar days of receipt of the policy.
2. Complete a risk management discussion call within 30 days of the policy being bound.
3. An onsite visit will be completed during the policy period at our discretion. We encourage your agent to also be part of this onsite visit.

Please complete:

Owner/decision maker name(s): _____

Contact phone number(s): _____

Contact email address(s): _____

Physical location for business operations: _____

Agent contact & agency: _____

Agent phone number: _____

If you do not receive a phone call within 10 days of the policy being bound, please contact one of our team members at 1-877-585-2851. We are available Monday through Friday, 7:00 AM-6:00 PM Mountain Time.

By signing below, I understand that I will need to complete a discussion call with the Risk Management Department within 30 days of policy being bound and return a signed copy of the Policy Receipt Form and Coverage Conditions Summary within 10 days of receipt of the policy. I also understand that there may be a required onsite visit completed at my physical location during the policy period to keep coverage in effect.

_____	_____
Applicant's signature	Signature of broker/agent of applicant
_____	_____
Print applicant's name	Print broker/agent name

Please Signature

CLAIMS HISTORY AND INCIDENT DISCLOSURE HISTORY

Return this Form

Coverage provided under any policy is contingent on the following warranty, requirements, and acknowledgements as evidenced by the insured's or agent for the insured's signature.

Are you aware of any prior incident, event, occurrence that might reasonably be expected to lead to a claim, lawsuit, notice of loss, or loss? **(YOU MUST MAKE A SELECTION)** ☐ **Yes** ☐ **No**

Date of incident	Description of Incident	Amount paid (if any)

If yes, please complete the following information **(PLEASE COMPLETE FO *EACH AND EVERY* INCIDENT):**

Incident history:

Insured name:	
Claimants name:	
Date of claim:	Date of case filing:
Additional defendants:	
Insurance carrier to whom claim/incident reported:	

Claim/Incident status:

Dismissed/opened:	Verdict/case outcome:
Final settlement of claim: $	

Detailed description of claim/incident:

What steps have you taken to reduce the chance of this type of claim/incident in the future? _____

By signing this document, the undersigned applicant/insured or applicant's agent hereby warrants and represents to the insurer that after a diligent review of the applicant's/insured's records all necessary information, and to the best of the applicant's/insured's knowledge, all of the information provided herein is complete, truthful, and accurate. The applicant further understands and agrees that any insurance policy or certificate issued by the insurer may, at the insurer's discretion, be rescinded and voided (null and void from the beginning) in the event that the applicant provides any incomplete, false, or misleading information of any kind on this document or on any other document relating to this insurance.

Applicant's/insured's name: _____

Applicant's/insured's signature: _____ Date: _____

Signature of applicant's broker/agent: _____ Date: _____

Printed name of applicant's broker/agent: _____

South Carolina Secretary of State

Business Entities Online

File, Search, and Retrieve Documents Electronically

CAROLINA MED TRANS LLC

Corporate Information

Entity Type: Limited Liability Company

Status: Good Standing

Domestic/Foreign: Domestic

Incorporated State: South Carolina

Important Dates

Effective Date: 10/21/2019

Expiration Date: N/A

Term End Date: N/A

Dissolved Date: N/A

Registered Agent

Agent: Corporation Service Company

Address: 1703 Laurel Street
Columbia, South Carolina 29201

Official Documents On File

Filing Type	Filing Date
Articles of Organization	10/21/2019

For filing questions please contact us at